

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28464

State File No. 7218

318

1003

Registrar's No. 7218

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7218			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 23 2630 Armand Pl.			
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Brothers Hospital				d. STREET ADDRESS (If rural, give location) 23 2630 Armand Pl.					
3. NAME OF DECEASED (Type or Print) a. (First) Joseph F. Reiss b. (Middle) F. c. (Last) Reiss			4. DATE OF DEATH (Month) (Day) (Year) August 17, 1949						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 12, 1880		9. AGE (In years last birthday) 69		10. MONTHS 5	11. DAYS 5	12. IF UNDER 1 YEAR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Insurance Agent- Life Insurance			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) Baden, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Stephen Reiss			13b. MOTHER'S MAIDEN NAME Suzanna Reiss			14. NAME OF HUSBAND OR WIFE Cecelia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Cecelia Reiss ADDRESS 2630 Armand Pl.					
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis with Fibrosis ANTECEDENT CAUSES Morbid conditions; if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. W. J. H. Herndon 8/12/49						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.	
19a. DATE OF OPERATION 8/19/49		19b. MAJOR FINDINGS OF OPERATION Chronic Myocarditis with Fibrosis				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) St. Louis (STATE) Mo.					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Heart Failure					
22. I hereby certify that I attended the deceased from Aug 15, 1949 , to Aug 17, 1949 , that I last saw the deceased alive on Aug 17, 1949 , and that death occurred at 11, 20A m., from the causes and on the date stated above.									
23a. SIGNATURE J. B. Lasater (Degree or title) M.D.				23b. ADDRESS 3506 Morris		23c. DATE SIGNED 8/18/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 20, 1949		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. AUG 19 1949		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons Und. Co. 2630 Gravois Ave.					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

....., Student Embalmer No.

working under my personal supervision.

Signed Robert F. Gebken

Signed.....
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.